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Nos. 09-958, 09-1158, and 10-283

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In The
Supreme Court of the United States

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California, *Petitioner,*

v.

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., A Nonprofit Corporation, et al.

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California, *Petitioner,*

v.

CALIFORNIA PHARMACISTS ASSOCIATION, et al.

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California, *Petitioner,*

v.

SANTA ROSA MEMORIAL HOSPITAL, et al.

On Writs Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

CONSOLIDATED BRIEF OF THE AMERICAN MEDICAL ASSOCIATION, AMERICAN DENTAL ASSOCIATION, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN ACADEMY OF FAMILY PHYSICIANS AND THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*

Amici are among the largest and most prominent medical and dental professional associations in the United States.[1] Collectively, the members of these professional associations provide medical and dental services to literally millions of patients covered by the Medicaid program. *Amici* are uniformly committed to promoting the betterment of public health and improved access to health and dental care for Medicaid recipients. They are profoundly interested in this case because its outcome will affect the ability of all Medicaid recipients to assure that they have access to medically necessary services as mandated by the Medicaid Act. States' failure to comply with the Medicaid Act's "equal access" provision has a well-documented and negative impact on patient care, often creating unnecessary risks and poor health outcomes. Restricting the availability of a remedy through the courts would leave the Congressional mandate of "equal access" an empty promise.

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[1] Pursuant to Rule 37, letters of written consent from the parties have been filed with the Clerk of the Court. In accordance with Rule 37.6, *Amici* state that no counsel for either party has authored this brief in whole or in part. Funding for this brief, in part, has come from the Litigation Center of the AMA and the State Medical Societies, a coalition among the AMA and the State Medical Societies, whose purpose is to represent the organized medical profession in the courts. With the exception of the funding provided by the Litigation Center, no person or entity, other than *Amici*, has made any monetary contribution to the preparation or submission of this brief.

The American Medical Association ("AMA") is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups, seated in the AMA's House of Delegates, substantially all physicians, residents and medical students in the United States are represented in the AMA's policy making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health.

American Dental Association ("ADA") is the world's largest professional association of dentists. The ADA is committed to the public's oral health, and to the ethics, science and professional advancement of dentistry. On behalf of its more than 155,000 members, the ADA occupies a prominent role in leading the profession through initiatives in advocacy, education, research and the development of standards that are essential for the safe, appropriate and effective delivery of oral healthcare. The Association is vitally concerned with access to care issues and serves as a principal advocate on issues affecting oral health.

The American Academy of Pediatrics ("AAP") is an Illinois not-for-profit corporation representing 60,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists. Founded in 1930, AAP has been a powerful voice for children's health through education, research, advocacy, and the provision of expert advice. Its mission is to attain optimal physical, mental, and social health and well-being for all infants, children, adolescents,

and young adults. AAP is the largest professional association of pediatricians in the world.

The American Congress of Obstetricians and Gynecologists ("ACOG") is an Illinois not-for-profit corporation representing more than 50,000 obstetricians and gynecologists and residents in obstetrics and gynecology. ACOG is dedicated to the advancement of women's healthcare and to establishing and maintaining the highest possible standards of practice. ACOG also promotes policy positions on issues affecting the specialty of obstetrics and gynecology and supports quality health care for every woman throughout her life.

The American Academy of Family Physicians ("AAFP"), headquartered in Leawood, Kansas, is the national association of family doctors. Founded in 1947 as a not-for-profit corporation, its members are physicians and medical students from all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and the Uniformed Services of the United States. As part of its mission, the AAFP seeks to improve the health of patients, families, and communities by serving the needs of members and their patients with professionalism and dignity and by advocating for public health.

The American College of Emergency Physicians ("ACEP") is a nonprofit, voluntary professional and educational society of over 29,000 emergency physicians practicing in the United States and other countries. Founded in 1968, ACEP is the nation's oldest

and largest association of emergency physicians. ACEP fosters the highest quality of emergency medical care through the education of emergency physicians, other health care professionals, and the public; the promotion of research; the development and promotion of public health and safety initiatives; and the provision of leadership in the development of health care policy.

Many of *Amici*'s members care for Medicaid patients. Low Medicaid reimbursement rates impose an unfair burden on those members who accept these patients, and additional members of *Amici* would care for Medicaid patients if the reimbursement rates were not prohibitively low.

SUMMARY OF ARGUMENT

The "equal access" provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), mandates that states accepting federal Medicaid funds set provider reimbursement rates using "such methods and procedures" as necessary to assure, among other things, that payments are "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." As a practical reality, however, the promise of "equal access" has been largely illusory for many of America's most vulnerable citizens. Federal courts, scientific researchers and governmental

bodies have consistently found a chasm between Medicaid and private insurance in the availability of needed health care services. Twenty years after the statutory enactment of the equal access mandate, discrepancies in access to care pervade. Members of the *Amici* see these discrepancies every day in their own practices. Whether it be a futile attempt to find a Medicaid-participating pediatric neurologist or dentist for a young patient or treating a Medicaid beneficiary in the emergency room who cannot find a primary care physician, there are constant reminders of the access crisis in our public health system.

There is a well-established and predictable correlation between Medicaid provider payments and physicians' willingness to treat Medicaid recipients. Indeed, the equal access provision was itself enacted with the common sense recognition that "without adequate payment levels, it is simply unrealistic to expect physicians to participate in the [Medicaid] program." H.R. Rep. No. 101-247, at 390 (1989). The United States Government Accountability Office ("GAO") recently reported that for physicians who choose not to participate in Medicaid and the Children's Health Insurance Program ("CHIP"), *95%* are influenced by low provider reimbursement rates. *See* "Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care," GAO-11-624, at 18 (hereinafter

referred to as "2011 GAO Report").[2] Nevertheless, state officials have engaged in widespread violations of the federal equal access mandate, wholly failing to consider the effect of rates on access to care and services.

Federal administrative enforcement provides no viable solution to the access crisis because Congress delegated only limited, and draconian, enforcement powers. The primary administrative enforcement tool – a revocation of funding – is severe and would cause further harm. Thus, without judicial remedies, this crisis will remain and likely worsen. If the courthouse doors are closed, the very people the Medicaid Act was intended to serve will have no reasonable hope that "equal access" will have any true meaning in their lives.

Such a result would also violate fundamental rule of law principles. "'This is a government of laws and not of men,' 'No man is above the law,' are . . . maxims showing the spirit in which Legislatures, executives and courts are expected to make, execute and apply laws." *Truax v. Corrigan*, 257 U.S. 312, 332 (1921). Yet, without judicial remedies, state officials' violations of federal law will go unchecked in direct contravention of these principles, all while beneficiaries suffer.

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[2] *Available at*: http://www.gao.gov/new.items/d11624.pdf.

It is, after all, the welfare of these beneficiaries that is of primary concern to the *Amici*. The real human suffering occasioned by noncompliance can be lost in a sterile discussion of the law. This is particularly true with the Medicaid Act, as it indisputably impacts the health of millions of low income Americans. This human importance of the Medicaid Act was aptly summarized by the United States District Court for the District of Columbia in *Salazar v. District of Columbia*, 954 F. Supp. 278, 281 (D.D.C. 1996):

> This case is about people – children . . . who are sick, poor, and vulnerable – for whom life, in the memorable words of poet Langston Hughes, "ain't been no crystal stair." It is written in the dry and bloodless language of "the law" – statistics, acronyms of agencies and bureaucratic entities, Supreme Court case names and quotes, official governmental reports, periodicity tables, etc. But let there be no forgetting the real people to whom this dry and bloodless language gives voice: anxious, working parents who are too poor to obtain medications or heart catheter procedures or lead poisoning screens for their children . . . Behind every "fact" found herein is a human face and the reality of being poor in the richest nation on earth.

If the equal access mandate is ever to fulfill its promise, these "real people" must have a voice in the courts.

In sum, if states are permitted to simply disregard the equal access provision with impunity, not only will violations of federal law go unchecked, but

millions of people, including millions of children, will continue to be placed at unnecessary risk of harm or even death. Judicial enforcement of the equal access provision is mandated as a matter of law and vital as a matter of fact. The *Amici* strongly urge this Court rule in favor of Respondents.

ARGUMENT

MEDICAID BENEFICIARIES MUST HAVE ACCESS TO THE COURTS TO ENFORCE THE EQUAL ACCESS PROVISION IN ORDER TO UPHOLD THE RULE OF LAW AND BECAUSE JUDICIAL ENFORCEMENT IS THE *ONLY* VIABLE MEANS TO REMEDY STATES' NONCOMPLIANCE WITH THE MEDICAID ACT

A. The Medicaid Act, Children's Health Care and the "Equal Access" Mandate

From very early on, it was evident that the Medicaid program was intended to improve health care for America's poor, with a particular emphasis on children's health. Title XIX of the Social Security Act, commonly known as the Medicaid Act, was first enacted in 1965. *See* Pub. L. No. 89-97, 79 Stat. 343 (1965) (codified as amendment at 42 U.S.C. § 1396). The Medicaid program, as established by the Medicaid Act, is a cooperative federal-state program for furnishing and financing health care and services to certain low income families and individuals. States

that choose to participate in Medicaid are required to provide coverage to seven designated classes of "categorically needy" persons, with the option to extend coverage to other designated individuals, known as "medically needy." *See* 42 U.S.C. §§ 1396a(a)(10)(A)(i), (a)(10)(C), (a)(17) and § 1396d.

In 1967, Congress amended the Medicaid Act to impose the explicit and mandatory children's health care program – which has come to be known as Early and Periodic Screening, Diagnosis and Treatment, or "EPSDT" – upon every state choosing to accept federal Title XIX funds. *See* Pub. L. No. 90-248, 81 Stat. 821 (1967). As this Court has previously noted, "EPSDT programs provide health care services to children to reduce lifelong vulnerability to illness or disease." *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 433-34 (2004).

The children's health amendments were enacted amidst growing concerns about the lack of available pediatric health care and correlative effects on education. In his February 8, 1967 "Special Message to Congress," President Johnson stated:

> Recent studies confirm what we have long suspected. In education, in health, in all of human development, the early years are the critical years. Ignorance, ill health, personality disorder – these are disabilities often contracted in childhood: afflictions which linger to cripple the man and damage the next generation. Our nation must rid itself of this bitter inheritance. Our goal must be clear – to

> give every child the chance to fulfill his promise.
>
> * * *
>
> I am requesting increased funds for the "Medicaid" program, including . . . legislation to expand the timely examination and treatment of . . . poor children. . . .
>
> * * *
>
> We look toward the day when every child, no matter what his color or his family's means, gets the medical care he needs, starts school on an equal footing with his classmates, seeks as much education as he can absorb – in short, goes as far as his talents will take him.

Available at: http://www.presidency.ucsb.edu/ws/index.php?pid=28438&st=Medicaid&st1=Johnson. At this early stage in the life of Medicaid, the President and Congress placed special emphasis on low income children's health care, recognizing the potential for Medicaid to influence growth and development and to act as a catalyst for equality in health care and education. Unfortunately, however, after passage of the children's health amendments, many of the problems identified by President Johnson in 1967 persisted.

In 1989, Congress statutorily specified the required elements of EPSDT in 42 U.S.C. § 1396d(r). *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 1989 U.S.C.C.A.N. (103 Stat. 2106) 2262-63. In defining EPSDT services, Congress required

states to include four types of specific services: preventive screening, vision, dental, and hearing examinations. In addition to these specific preventive services, the statute mandates the provision of:

> [s]uch other necessary health care, diagnostic services, treatment, and *other measures described in subsection (a)* of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, *whether or not such services are covered under the State plan.*

42 U.S.C. § 1396d(r)(5)(emphasis added). In other words, the EPSDT mandate broadly requires that states furnish covered children (individuals under the age of 21) with *all medically necessary health care services. See, e.g., S.D. ex rel. Dickson v. Hood,* 391 F.3d 581, 590 (5th Cir. 2004); *Collins v. Hamilton,* 349 F.3d 371, 376 n. 8 (7th Cir. 2003).

As noted in the House Report generated in connection with the 1989 amendments, "[t]he EPSDT benefit is, in effect, the nation's largest preventative health care program for children." H.R. Rep. No. 101-247, 398-401, reprinted in 1989 U.S.C.C.A.N. 1906, 2124. Congress further left no doubt of its intent that children covered by Medicaid actually receive the services mandated by the EPSDT amendments. *Id.* at 2124-25. To this day, the Medicaid Act's EPSDT program is the primary source of necessary and vital health care services for millions of America's children.

Recognizing that the "eligibility expansions . . . for poor pregnant women . . . and poor children will not have their intended effect if physicians are not willing to treat Medicaid patients,"[3] Congress also enacted, as part of the 1989 amendments, the "equal access" provision. *See* 42 U.S.C. § 1396a(a)(30)(A). Consistent with the overall Congressional goal of improving children's health, the House Report indicates that the equal access provision was enacted, in large part, to address concerns over "inadequate" Medicaid participation of "physicians generally, and obstetricians and pediatricians in particular. . . ." H.R. Rep. No. 101-247 at 389 (1989). The House Committee found that Medicaid payment rates were an "important factor" in a physician's decision whether to accept Medicaid patients and was persuaded by hearing testimony that Medicaid payment rates had not kept pace with average community rates. *Id.* at 389-90. The House Report expresses a clear and common sense statement of the connection between provider payment rates and recipient access to health care services: "the Committee believes that, *without adequate payment levels, it is simply unrealistic to expect physicians to participate in the program.*" *Id.* at 390 (emphasis added).

In 1997, Congress created CHIP, Title XXI, to give states the option of covering additional uninsured children with family incomes up to 200% of the

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[3] H.R. Rep. No. 101-247 at 390 (1989).

poverty level. *See* 42 U.S.C. §§ 1397aa; 1397jj(c)(4). Under CHIP, states are given flexibility to simply expand traditional Medicaid coverage. *See* 42 U.S.C. §§ 1397aa(a), 1397ee(c)(2). Funding for CHIP was renewed as part of the CHIP Reauthorization Act of 2009. *See* P.L. 111-3, 123 Stat. 8 (2009).

Judicial enforcement of substantive Medicaid Act provisions was contemplated by Congress. Eight years prior to the 1989 amendments, the House Committee Report on amendments to the Medicaid Act provided: "in instances where the States or the Secretary fail to observe these statutory requirements, the *courts would be expected to take appropriate remedial action.*" H.R. Rep. No. 97-158 at 301 (1981) (emphasis added). As the Third Circuit later observed, "[t]his statement certainly suggests that the Committee anticipated *that some class of plaintiffs would be able to sue to enforce Section 30(A). . . .*" *Pennsylvania Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 541 (3rd Cir. 2002) (en banc) (Alito) (emphasis added).[4] In the same vein, the Health Care

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[4] The present case arises from circumstances in which the Supremacy Clause has been invoked to secure state compliance with the Medicaid Act's equal access mandate. The enforceability of the equal access mandate under 42 U.S.C. § 1983 is not at issue in this case and need not be decided by this Court. In any event, these *Amici* maintain that such a private right of action does exist pursuant to § 1983, and they are joined in that proposition by the district court holding in *Florida Pediatric Society v. Dudek*, 05-23037-CIV (S.D.Fla., Sept. 30, 2009) (Dkt. #672) (relying on *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990)).

Financing Administration ("HCFA"), now the Centers for Medicare & Medicaid Services ("CMS"), later warned state Medicaid directors that "[i]nadequate Medicaid non-institutional provider rate structures may expose a state to serious litigation risk [with respect to equal access claims]." Letter from HCFA Director to State Medicaid Directors, SMDL #01-010, at 3 (Jan. 18, 2001), *Available at*: https://www.cms.gov/smdl/downloads/ smd011801a.pdf.[5]

B. The Access Gap Between Congressional Promise and Actual Implementation

There are approximately 61 million Medicaid enrollees in the United States, of whom 33 million are under age 21 and 31 million are under the age of 19. *See* Medicaid State Reports, FY 2008, published by CMS for Federal Fiscal Year 2008.[6] This is the equivalent of 37.6% of the total population of persons under age 21 and 38.9% of the total population under age 19. Despite the undeniable prominence and importance of Medicaid as a health insurer in America, there remain vast disparities between Medicaid and private insurance[7] in the availability of medically

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[5] In the same letter, the HCFA Director indicates that as of January 2001, there had been 22 dental access cases in 18 States, and of those, 16 had been decided or settled favorably for the plaintiffs. *See* Letter from HCFA Director at 3.

[6] *Available at*: http://www.aap.org/research/pdf08/US.pdf.

[7] Courts have found that "the test for evaluating access is to compare the access of [beneficiaries] living in a specific

(Continued on following page)

necessary health care. Testimony from physicians, dentists and beneficiaries alike in litigation involving noncompliance with the Medicaid Act's equal access and EPSDT provisions paint the picture of a truly inferior health care system for Medicaid recipients. It is a system under which medically inappropriate delays in treatment are commonplace, putting patients, most especially children, at unnecessary risk.

Large percentages of recipients receive no mandatory preventive health screening examinations. Primary care providers struggle to find specialists willing to accept Medicaid enrolled patients. Medicaid enrolled children may wait upwards of one year to see a pediatric neurologist, or they may have to travel out-of-state to find an available specialist. Many Medicaid recipients have simply given up on finding *any* dentist who accepts Medicaid. There are even documented instances of young Medicaid recipients dying while awaiting necessary treatment. Regrettably, constrained, nonexistent access for Medicaid

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geographic area [to] the access of [other] individuals in the same area [with] private or public insurance coverage." *Clark v. Kizer*, 758 F. Supp. 572, 576 (E.D.Cal. 1990), *aff'd in relevant part sub nom.*, *Clark v. Coye*, 967 F.2d 585 (9th Cir. 1992) (citing H.R. Rep. No. 101-247, at 390-91). *See also Ark. Med. Soc'y v. Reynolds*, 6 F.3d 519, 527 (8th Cir. 1993) ("To suggest that Congress appropriated vast sums of money and enacted a huge bureaucratic structure to ensure that recipients of the federal Medicaid program have equivalent access to medical services as their uninsured neighbors (i.e., close to none) is ridiculous.")

recipients is no rarity. By contrast, the insured population does not usually face such access problems.

As one court summarized after a full trial on the merits of an equal access claim:

> Most doctors in Cook County [, Illinois] will either not see children on Medicaid or significantly limit the number of children on Medicaid that they will accept as patients.
>
> * * *
>
> A substantial number of children on Medicaid have had adverse health outcomes because they have not been able to see a pediatrician regularly due to their difficulty in finding a pediatrician. In addition, waiting times in specialty treatment clinics for the plaintiffs are long and oftentimes put patients in danger.
>
> * * *
>
> Medicaid recipients may have to travel great distances to find a dentist or pediatric provider willing to accept Medicaid, if they can find one at all. Children on Medicaid frequently seek care at emergency rooms because they cannot find a pediatrician willing to accept Medicaid.

Memisovski v. Maram, 2004 WL 1878332, *17-18 (N.D.Ill., Aug. 23, 2004).

Several other courts in geographically diverse locations have made similar findings over the years. *See, e.g., Oklahoma Chapter of the American Academy*

of Pediatrics ("OKAAP") v. Fogarty, 366 F. Supp. 2d 1050, 1107 (N.D.Okla. 2005), *rev'd, OKAAP v. Fogarty,* 472 F.3d 1208, 1215 (10th Cir. 2007) ("[T]he lack of physician participation in Medicaid forces class members either to wait for unreasonable periods of time to receive needed care or to travel long distances to find Medicaid participating providers, putting these children at risk of harm or even death.");[8] *Rosie D. v. Romney,* 410 F. Supp. 2d 18, 23 (D.Mass. 2006) ("At present, thousands of needy . . . children [diagnosed with serious emotional disturbances] lack comprehensive assessments; treatment occurs haphazardly, with no single person or entity providing oversight and ensuring consistency"); *Health Care for All v. Romney,* 2005 WL 1660677, *10 (D.Mass., July 14, 2005) ("Plaintiffs' evidence shows that [Medicaid] enrollees encountered extraordinary difficulty in obtaining timely dental services"); *Salazar v. District of Columbia,* 954 F. Supp. 278, 304 (D.D.C. 1996)

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[8] The Tenth Circuit Court of Appeals reversed the *OKAAP* district court's determination that the defendants violated the equal access mandate on purely legal grounds, determining that the plaintiffs had no right to enforce the equal access provision pursuant to 42 U.S.C. § 1983. *OKAAP,* 472 F.3d at 1215. The Tenth Circuit did *not* challenge the district court's underlying findings of fact. To the extent that the Tenth Circuit addressed the findings at all, it conceded that the district court "perhaps correctly" concluded that the "low rates of reimbursement reduce the number of providers available to Medicaid beneficiaries, and in turn increase the time Medicaid beneficiaries must wait to receive medical services from available providers. . . ." *Id.* at 1214; *see also id.* at 1209 (noting "system-wide delays in treatment of Medicaid beneficiaries").

("Plaintiffs have produced significant evidence to show that Defendants have failed to deliver EPSDT services to eligible children"); *Clark v. Kizer,* 758 F. Supp. 572, 576 (E.D.Cal. 1990), *aff'd in relevant part sub nom., Clark v. Coye,* 967 F.2d 585 (9th Cir. 1992) ("The undisputed facts in this case establish that less than 40% of the licensed dentists in the state treat any Denti-Cal recipients."). All of these findings, of course, were made prior to the additional strains on the Medicaid system that have arisen from the current economic downturn.

Published scientific studies also consistently confirm that access to health care and dental services is generally poor for Medicaid recipients when compared to access enjoyed by the privately-insured population. *See, e.g.,* J. Bisgaier et al., *Disparities in Child Access to Emergency Care for Acute Oral Injury,* 127 Pediatrics e1428 (2011); J. Bisgaier & K. Rhodes, *Auditing Access to Specialty Care for Children with Public Insurance,* 364 New Eng. J. Med. 2324 (2011); S. Decker, *Medicaid Payment Levels to Dentists and Access to Dental Care Among Children and Adolescents,* 306 JAMA 187 (2011); C. Iobst et al., *Access to Care for Children with Fractures,* 30 J. Pediatric Orthopaedics April/May 2010 at 244; A. Skinner & M. Mayer, *Effects of Insurance Status on Children's Access to Specialty Care: A Systemic Review of the Literature,* 7 BMC Health Serv. Res. 194 (2007); D. Skaggs et al., *Access to Orthopedic Care for Children with Medicaid Versus Private Insurance: Results of a National Survey,* 26 J. Pediatric Orthopaedics

May/June 2006, at 400; Medical Access Study Group, *Access of Medicaid Recipients to Outpatient Care,* 330 New Eng. J. Med. 1426-30 (1994). Similar studies have been presented by expert witnesses, admitted into evidence, and relied upon by courts in finding violations of the "equal access" provision. For instance, the United States District Court for the Northern District of Oklahoma relied upon survey results showing that only 34% of Oklahoma's pediatricians accepted all new Medicaid patients, while 69% accepted all new privately insured patients. *OKAAP*, 366 F. Supp. 2d at 1063; *see also Memisovski,* 2004 WL 1878332 at *13.

Recent data demonstrate that Medicaid's access conundrum is widespread and continuing. The 2011 GAO Report documents the results of a nationwide study of children's access to care under Medicaid and CHIP, including information on physicians' willingness to serve children covered under these public health care programs. *See* 2011 GAO Report at 1.[9] Some of the findings are alarming. For instance, GAO found that about 80% of physicians are accepting all

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[9] Medicaid and CHIP are closely related public health programs. As GAO states, both Medicaid and CHIP are "joint federal-state health care programs for certain low income individuals" which "play a critical role in addressing the health care needs of children." 2011 GAO Report at 1. Furthermore, there are approximately five times as many children covered under Medicaid as children covered under CHIP. *Id.* at 4. Thus, data concerning access to care with respect to Medicaid and CHIP combined is indicative of access under Medicaid alone.

privately insured children as new patients, while less than 50% accept all Medicaid and CHIP children. *See* 2011 GAO Report at 10. GAO further estimates that 84% of participating physicians experience difficulty in referring Medicaid and CHIP children to specialists, compared with 26% for privately insured children. *Id.* at 20. Most dramatically, GAO specifically reports that while 34% of physicians experience "great difficulty" in referring Medicaid and CHIP children, only 1% of physicians experience such difficulty in referring privately insured children. *Id.* at 21.

In 2000, the Surgeon General reported that "Medicaid has not been able to fill the gap in providing dental care to poor children" and that "[f]ewer than one in five Medicaid children received a single dental visit in a recent year-long study." U.S. Department of Health and Human Services, *Oral Health in America: A Report of the Surgeon General – Executive Summary* (2000). By 2008, the situation had not significantly improved. GAO found that dental disease and inadequate receipt of dental care remained a serious problem for children in Medicaid, with only about one in three such children receiving *any* dental care. *See* GAO, "Medicaid: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay," GAO-08-1121, at 4 (2008). By contrast, more than one-half of privately insured children had received dental care. *Id.*

The lack of dental access can have tragic consequences. In 2007, a 12-year-old Medicaid recipient in Maryland – Deamonte Driver – died from a brain infection caused by untreated tooth decay. *See Evaluating Pediatric Dental Care under Medicaid: Hearing before the Subcommittee on Domestic Policy of the House Committee on Oversight and Government Reform* (Serial 110-8), 110th Cong., at 2-4; 13-19 (May 2, 2007).[10] Prior to his death, Deamonte's mother had unsuccessfully attempted to find a Medicaid-participating dentist to provide preventive dental care for her sons. *Id.* After Deamonte began experiencing severe headaches, he was diagnosed with a sinus infection and later rushed to the hospital. *Id.* at 13, 19. Over a period of six weeks in the hospital, Deamonte valiantly fought through two brain surgeries and a tooth extraction, only to suddenly pass away on February 25, 2007. *Id.* at 19.

Tellingly, GAO estimates that for providers who choose not to participate in Medicaid and CHIP, 95% are influenced by low provider reimbursement rates. *See* 2011 GAO Report at 18. While greatly concerning, this finding comes as little surprise to the *Amici*. For many years, provider payment rates have been linked to physicians' willingness to participate in Medicaid. Fundamentally, the Medicaid Act's equal access provision was enacted over two decades ago with the

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[10] *Available at*: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_house_hearings&docid=f:35772.pdf.

recognition that physicians will simply not participate in Medicaid if payments are inadequate. *See, e.g.*, H.R. Rep. No. 101-247 at 390 (1989). Since enactment, several federal courts have determined that particular states' Medicaid provider rates were insufficient to satisfy the equal access mandate. *See, e.g., Clark,* 758 F. Supp. at 577 ("The uncontroverted evidence in the record before the court . . . establishes that the present rates are not even adequate to meet overhead, let alone allowing for some marginal profit"); *Memisovski,* 2004 WL 1878332 at *45 ("Employees of the [Illinois Department of Public Aid] freely admit that rates are low and not very attractive and are set without regard to the effect such rate-setting will have on access. . . ."); *OKAAP*, 366 F. Supp. 2d at 1106 ("The record in this case demonstrates that [Oklahoma Health Care Authority] has frequently set rates below the levels which OHCA admits are adequate to assure there are enough providers to serve Medicaid enrolled children. . . .").

The continuing access crisis under Medicaid is due, in large part, to the draconian nature of the administrative enforcement mechanism. As noted *supra*, the only true enforcement tool available to the Secretary of Health and Human Services ("HHS") – a revocation of funding – would further harm the very beneficiaries the Medicaid Act was intended to protect. *See* 42 U.S.C. § 1396c.[11] By contrast, private

[11] The current administration recently proposed a Medicaid "equal access" rule. *See* Standards for Demonstrating Access to

(Continued on following page)

lawsuits offer the possibility of increased state funding, with a real benefit to recipients in need. While such increases have actually been achieved through private legal actions, no increases have ever been achieved through HHS enforcement. Private litigation offers the only realistic prospect of an effective remedy for states' often flagrant violation of the Medicaid Act. Thus, the availability of these lawsuits is crucial, and this Court ought not diminish this necessary vehicle for achieving the Congressional purpose.

C. A Litigation Case Study of the Human Implications of States' Failures to Comply With the Medicaid Act

As foreseen by Congress and later warned of by HCFA, over the years since the 1989 amendments,

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Covered Medicaid Services, 76 Fed. Reg. 26,342-62 (2011). However, the proposed rule calls for no concrete guidelines and states the administration's intent that any final rule would not directly "require States to adjust payment rates." *Id.* at 26,344. It is also unclear, whether or how, the administration plans to enforce any such equal access rule. Indeed, neither the word "enforcement" nor "enforce" appears anywhere in the proposed rule. As several of the *Amici* recently summarized in comments on the proposed rule, "[w]ithout enforcement and comprehensiveness, CMS will have missed the opportunity to ensure that children and other populations covered under Medicaid have real access to care." Letter from AAFP, et al. to K. Sebelius (June 20, 2011), *Available at*: http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/endorse-letters/medicaid062011.Par.0001.File.tmp/JointMedicaid062011.pdf.

many Medicaid beneficiaries have brought actions to enforce the equal access provision and/or EPSDT provisions of the Medicaid Act. Dealing with a broken system and with nowhere else to turn for relief, desperate beneficiaries and courageous physicians have looked to the courts to compel states' compliance. In the relatively rare instances when one of these cases has gone to a full trial on the merits, the courts' findings of fact have vividly illustrated the "real world" implications of a noncompliant Medicaid program. Courts have found large-scale failures to provide necessary services to those in need, medically inappropriate and dangerous delays in treatment and demonstrable disparities in access to needed care.

For the purposes of this Brief, the *Amici* focus on three such cases – *Memisovski v. Maram,* 2004 WL 1878332 (N.D.Ill., Aug. 23, 2004), *OKAAP v. Fogarty,* 366 F. Supp. 2d 1050 (N.D.Okla. 2005), and *Health Care for All v. Romney,* 2005 WL 1660677 (D.Mass., July 14, 2005)[12] – which detail, sometimes tragically, the very reasons it is absolutely vital that Medicaid beneficiaries (and perhaps health care providers) have access to the courts.

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[12] Unlike the underlying cases at bar, which were brought pursuant to the Supremacy Clause, *Memisovski*, *OKAAP* and *Health Care for All* were brought pursuant to 42 U.S.C. § 1983.

1. *Memisovski v. Maram*

The *Memisovski* case was a class action brought on behalf of all Medicaid-eligible children in Cook County, Illinois. Cook County is the second most populous county in the United States.[13] By the time the *Memisovski* case was tried, approximately 600,000 Cook County children were on Medicaid. *See Memisovski,* 2004 WL 1878332 at *11.

After the trial was completed, the *Memisovski* court issued its ruling in favor of the plaintiffs, bolstered by extensive findings of fact and conclusions of law. *Id.* at *11-56. The court's findings of fact read like a veritable laundry list of everything that could possibly go wrong with a state's Medicaid system. And it is apparent that much of the evidence put on by the *Memisovski* plaintiffs, which showed blatant and systemic violations of the equal access and EPSDT mandates, was not meaningfully contested by the Illinois state official defendants. *See, e.g., id.* at *45 ("defendants have no knowledge regarding the state of access for Medicaid-enrolled children in Cook County and have never tried to learn what the level of access might be. . . .")[14]

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[13] *See*: Cook County, Illinois, Geographic Information System, GIS History, http://www.cookcountygov.com/portal/server.pt/community/geographic_information_systems/315/gis_history.

[14] In fact, as lead counsel for the *Memisovski* plaintiffs represented, defendants initially took the position they were complying with the Medicaid Act because access to care was *no worse* in Illinois than in other industrial states. *See* F. Cohen, *An Unfulfilled Promise of Medicaid Act: Enforcing Medicaid*

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The *Memisovski* court's findings chronicle both statistical and anecdotal evidence of a Medicaid system in ruin. The findings exposed a system that often provided no health care at all, let alone "equal access." As noted above, the court determined that most physicians in Cook County either did not see Medicaid-enrolled children at all, or they significantly limited their Medicaid practices. *See Memisovski*, 2004 WL 1878332 at *17. This lack of available providers had a predictable negative effect on patient care. For instance, the court found that approximately 90% of Medicaid-enrolled children in Cook County had never received a vision examination, 80% had never received a hearing examination and 75% had never received a dental examination. *Id.* at *30. The court relied upon expert analysis showing that approximately one-third of the pediatric Medicaid population had never received "any preventive health care at all." *Id.* at *23.

Recipients' Right to Health Care, 17 Loy. Consumer L. Rev. 375, 390 (2005). What is more, according to counsel, defendants made this argument without conducting any analysis as to whether any of these other "industrial states" were complying with the Medicaid Act. *Id.* Given the Illinois defendants' attitude about compliance, the disintegration of the Medicaid system in Cook County should have come as no surprise. Such an attitude on the part of state Medicaid agencies is not uncommon and further exemplifies the need for enforcement in the courts. Ironically, though, there is no reason to doubt that this assertion by defense counsel was substantively correct – access to care under the Illinois Medicaid program may well have been no worse than in other industrial (as well as non-industrial) states.

"[M]any of the physicians testified that Medicaid children frequently use the emergency room as a source of primary care because they simply have nowhere else to go." *Id.* at 44. Dr. Steven Lelyveld, from the University of Chicago Hospitals' pediatric emergency room, testified that Medicaid-enrolled children with asthma, gastroenteritis, flu and diabetes "frequently presented [at the emergency room] with more aggravated or serious symptoms . . . as a result of lack of primary care." *Id.* Dr. Steven Krug, head of the emergency room at Children's Memorial Hospital in Chicago, testified that Medicaid patients in the emergency room frequently arrived with "conditions that privately-insured patients do not typically have and which reflect a lack of primary care, including untreated bone fractures or advanced asthmatic conditions." *Id.*

The *Memisovski* court also relied on the testimony of Medicaid recipients, such as Yesinia Rodriguez. Ms. Rodriguez testified concerning the extraordinary difficulty she had in locating a physician in Cook County who would accept Medicaid. When she called the Illinois hotline for a physician referral, she was given the names of approximately ten different doctors, all of whom practiced more than 30 miles away and *none* of whom accepted Medicaid. *Memisovski,* 2004 WL 1878332 at *18. When Ms. Rodriguez called the hotline back, she was given contact information for 20 more doctors. *Id.* Once again, however, *not one* of these doctors accepted Medicaid. *Id.*

The court's findings concerning Illinois' Medicaid payment rates explained why access to needed care was so inadequate for Cook County's Medicaid population. Indeed, the Illinois defendants admitted that Medicaid rates were low and unattractive and that the rates were set without any consideration of the effect on access. *Id.* at *45. The court found that Medicaid rates in Illinois were approximately 50% of Medicare rates[15] and that "[a] pediatrician practice relying solely on Medicaid beneficiaries' maximum reimbursements could not survive since Medicaid pays nearly 10% less than the median practice costs." *Id.* at *12-13. In summarizing the overwhelming evidence put on by the plaintiffs, the *Memisovski* Court stated:

> Testimony showed that Medicaid-enrolled children face conditions such as longer waiting times for care . . . , a more limited population of providers willing to provide care . . . , and multiple trips to the doctor for services which could be addressed in one visit. . . . All in all, the doctors painted a picture of Medicaid-enrolled patients being afforded a significantly lesser degree of access to care than that enjoyed by privately-insured children.

Memisovski, 2004 WL 1878332 at *43. Two generations after President Johnson publicly envisioned a

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[15] Medicare rates are an important benchmark because Medicare rates are set to allow a physician to recover overhead costs and a modest profit. *Id.* at *12.

day when, through Medicaid, "every child, no matter what his color or his family's means, gets the medical care he needs," the Medicaid system in one of most populous areas in the United States was in complete collapse.

2. *OKAAP v. Fogarty*

In *OKAAP*, as in *Memisovski*, the plaintiffs were successful in proving wholesale violations of the equal access mandate. And in the each of these cases, the district court issued detailed findings of fact evincing noncompliant and badly broken Medicaid programs. The *OKAAP* district court's findings and conclusions meticulously set out the Oklahoma defendants' continuing, serious and knowing failures to assure that eligible children received health care services as required by the Medicaid Act. In determining the defendants had violated the equal access provision, the *OKAAP* court summarized:

> The testimony from providers and parents of class members alike was that recipients have great difficulty accessing needed health care services in Oklahoma. As plaintiffs established, the lack of physician participation in Medicaid forces class members either to wait for unreasonable periods of time to receive needed care or to travel long distances to find Medicaid participating providers, putting these children at *risk of harm or even death*.

> . . . The testimony at trial also demonstrated that providers are widely opting out of the Medicaid program or restricting their Medicaid caseloads.
>
> . . . Finally, defendants admitted at trial that reimbursement rates are inadequate and that the equal access provision is being violated.

OKAAP, 366 F. Supp. 2d at 1107 (emphasis added).

The evidence in the *OKAAP* case brought to light troubling facts concerning the state of health care for Oklahoma's young Medicaid population. For instance, the court found that one young Medicaid patient died while awaiting a delayed airway surgery. *OKAAP*, 366 F. Supp. 2d at 1100. At the time of the class certification hearing, named plaintiff Katelyn W. had been unable to secure a medically necessary prosthetic shoe insert to replace her amputated foot. *Id.* at 1088. The primary care physician ("PCP") of Jacob H., another named plaintiff, had attempted, without success, for approximately three years to find *any* Medicaid-participating facility to perform a necessary diagnostic sleep study. *Id.*

In this regard, the court found generally that "recipients in Oklahoma often experience long delays in obtaining appointments for provision of medically necessary care." *OKAAP*, 366 F. Supp. 2d at 1079. Access to neurological care was an area of particular concern. Pediatric Medicaid patients in Oklahoma City with seizure disorders were forced to wait

"*around a year* to be seen by a pediatric neurologist." *Id.* at 1067 (emphasis added). Some of these patients had poorly controlled seizures, and, as the court found, without the prompt care of a neurologist the seizures would negatively impact school performance, development, behavior, and the "'overall medical well-being'" of these children. *Id.* (quoting from Tr. Vol. I at 54:7-16). The court particularly noted the chilling account of one parent who told of being forced to drive her daughter for four hours to see a pediatric neurologist, and her daughter's experiencing a severe seizure *en route*. *Id.*

At the time of trial, office-based ear, nose and throat ("ENT") specialists in Oklahoma simply refused to treat children on Medicaid. *OKAAP*, 366 F. Supp. 2d at 1067-68. "The lack of Medicaid participation by private practice ENT specialists . . . created 'almost a crisis situation' at the [Oklahoma University] Medical Center in Oklahoma City." *Id.* at 1068 (internal quotation omitted). Dr. Richard Ranne, a pediatric thoracic surgeon in Tulsa, described access to orthopedists who accept Medicaid as "extremely poor." *Id.* at 1069. The court noted the testimony of another Tulsa pediatrician regarding "a six-week ordeal his office encountered attempting, without success, to secure an orthopedic consult for a four-year-old girl with a fractured toe." *Id.* at 1069.

Statistical and anecdotal evidence alike showed significant disparities between access to care under Medicaid when compared with access under private

plans. Survey data showed that only 34% of Oklahoma's pediatricians participated fully in the Medicaid program, while 69% of Oklahoma's pediatricians accepted all new privately insured patients. *OKAAP*, 366 F. Supp. 2d at 1063. The many physicians who testified at trial corroborated these statistics. A pediatric neurologist, who had ceased participation in Medicaid, testified that children on Medicaid did not have the same access to neurological services provided to children with private insurance "because of low or nonexistent Medicaid reimbursement." *Id.* at 1067. Another pediatrician testified that while access to ENT specialists was extremely poor for Medicaid patients, children with private insurance had "no problems" accessing ENT services. *Id.* at 1068.

Consistent with the results of the recent national survey conducted by the GAO, the *OKAAP* court found that approximately ninety-three percent (93.2%) of Oklahoma's pediatricians reported that low reimbursement is a "very important" reason they would limit their participation in the Medicaid program. *OKAAP*, 366 F. Supp. 2d at 1075. From 1995 through December 31, 2003, provider reimbursement under Oklahoma's Medicaid fee-for-service schedule never exceeded 72% of Medicare. *Id.* at 1059. By contrast, under commercial plans, Oklahoma physicians were reimbursed at rates of 130% to 180% of Medicare. *Id.* at 1060. As the CEO of Oklahoma's Medicaid agency candidly admitted, Oklahoma's Medicaid physician reimbursement rates

"are low, were low, and that this is a factor that makes it difficult to recruit physicians." *Id.* at 1075.

3. *Health Care for All v. Romney*

The *Health Care for All* case involved claims that responsible officials had failed to meet the dental needs, to the extent required by the Medicaid Act, of children and adults enrolled in Massachusetts' Medicaid program.[16] *See* 2005 WL 1660677. The court's findings revealed an absence of adequate access to mandatory dental care under Massachusetts' Medicaid program. *See, e.g., id.* at *2-7.

First, the court found that "[e]ach testifying plaintiff confronted hardships in identifying [Medicaid] participating dentists, obtaining appointments for dental care and receiving quality services." *Id.* at *2. One plaintiff, Ms. Curtis, worked diligently to find a single dental office willing to accept her Medicaid-enrolled children, only to subsequently discover that single dental office had closed its doors to Medicaid beneficiaries. *Id.* at *2. By the time Ms. Curtis had put together the money to pay out of pocket for her children to be seen by a solo practitioner, her sons had over 13 cavities. *Id.* Another young Medicaid beneficiary suffered an infected molar and could not

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[16] While the allegations made by the plaintiffs in *Health Care for All* factually resemble an equal access claim, the plaintiffs brought their claims under the Medicaid Act's "reasonable promptness" provision, 42 U.S.C. § 1396a(a)(8).

attend school, eat or sleep due to the pain until a Medicaid-participating dentist could be located to extract the tooth. *Id.* at *3. The court found that a mother searched for two months to identify an oral surgeon who accepted Medicaid and would perform extractions for her son whose permanent teeth were not developing properly. *Id.*

Second, the court relied upon statistical evidence that *86%* of licensed dentists in Massachusetts refused to accept Medicaid patients. *Id.* at *3.

Third, and importantly, the *Health Care for All* court compared access to dental care under Medicaid with access under Delta Dental, a commercial plan. *See, e.g., id.* at *5. Specifically, the Commonwealth defendants' own statistics showed that only slightly more than 30% of Medicaid-enrolled children received at least one dental visit each year for the years 2001, 2002, and 2003. *Id.* In contrast, 80 to 85% of children covered by Delta Dental had accessed such dental care. *Id.*

Fourth, the court found a clear connection between low Medicaid reimbursement and inadequate dental care. At the time of trial, Medicaid dental rates were "dramatically below . . . market levels" such that Medicaid-participating dentists could cover only about 75% of their costs. *Id.* at *4. In particular, plaintiffs established that Medicaid reimbursement rates were "so low that private dentists could not afford to treat enrollees who, thus, either received dental care only after much delay or not at all." *Id.* at *11.

D. The Availability of Judicial Remedies for Violations of the Equal Access Provision is Both Legally Mandated and Vital to Upholding the Rule of Law and Beneficiaries' Rights

Congress expected that courts would enforce § 1396a(a)(30)(A). *See, e.g., Pennsylvania Pharmacists Ass'n,* 283 F.3d at 541 (then-Judge Alito discussing legislative history and observing that "statement certainly suggests that the Committee anticipated that some class of plaintiffs would be able to sue to enforce Section 30(A). . . ."). The grievous deficiencies within the Illinois, Oklahoma and Massachusetts Medicaid programs would likely never have been addressed had the *Memisovski, OKAAP* and *Health Care for All* cases not been filed and prosecuted. All indications are that, without court intervention, the Medicaid programs in those states would have simply languished in perpetual noncompliance while beneficiaries suffered without recourse. As shown, the only effective enforcement tool available to the Secretary of HHS – revocation of a state's federal funding (*see* 42 U.S.C. § 1396c) – is the administrative equivalent of a nuclear bomb. "[A] funds cutoff is a drastic remedy with injurious consequences to the supposed beneficiaries of the Act." *Pennhurst State Sch. & Hosp. v. Halderman,* 451 U.S. 1, 52 (1981) (White J., dissenting). That is, were the Secretary to revoke funding of a State's Medicaid program for noncompliance with the equal access mandate, recipients would lose health care coverage altogether, turning a crisis into a catastrophe.

This leaves the federal courts as the only meaningful option. With no access to the courts, suffering beneficiaries will have no viable means for remedial relief. In addition, those state officials responsible for noncompliant Medicaid programs would never be called to task in contravention of fundamental rule of law principles. The classic American formulation of these principles can be traced back to John Adams and his Declaration of Rights in the Massachusetts Constitution of 1780. Article XXX applied the doctrine of separation of powers to the government of the Commonwealth " . . . to the end it may be a government of laws and not of men." This Court has since broadly recognized this "maxim." *Truax*, 257 U.S. at 332.

The rule of law doctrine applies with particular force to governmental bodies – even states – whose very existence depends on this country's laws and the respect of the population for those laws. Justice Brandeis eloquently stated the general principle:

> In a government of laws, existence of the government will be imperiled if it fails to observe the law scrupulously. Our government is the potent, the omnipresent teacher. For good or ill, it teaches the whole people by its example. Crime is contagious. If the government becomes a lawbreaker, it breeds contempt for law; it invites every man to become a law unto himself; it invites anarchy. . . . Against that pernicious doctrine this court should resolutely set its face.

Olmstead v. United States, 277 U.S. 438, 485 (1928) (Brandeis, J., dissenting). In *Marbury v. Madison,* Justice Marshall famously addressed the subordination of public officials to the rule of law as follows: "where a specific duty is assigned by law, and individual rights depend upon the performance of that duty, it seems . . . clear that the individual who considers himself injured, has a right to resort to the laws of his country for a remedy." 5 U.S. 137, 166 (1803) (emphasis added).

The equal access mandate is not being observed scrupulously. On the contrary, it is evident that the mandate is being violated by states on a wide scale. And, at the very least, the equal access provision of § 1396a(a)(30)(A) assigns a duty of performance to the states which is necessary in assuring that individual rights – such as the right to receive medically necessary services under the EPSDT provisions – are realized. Without an adequate network of health care providers willing to accept Medicaid patients, recipients will not receive the services guaranteed by the Medicaid Act; and without adequate payments to providers, there will not be enough providers willing to accept Medicaid patients. The specific duties assigned to responsible governmental officials by the equal access provision are central to beneficiaries' rights and well-being. If recipients are barred from holding government officials to account for shirking their legal duties, those officials will escape the rule of law, and suffering recipients will be denied the "right to resort to the laws of this country for a remedy" as envisioned by the *Marbury* Court.

The remedial powers of the federal courts offer genuine hope to the millions of Medicaid beneficiaries without access to prompt and quality medical or dental services. In particular Medicaid Act cases where plaintiffs have been successful in prosecuting or settling their claims, courts have been able to construct effective remedial orders. Courts have issued preliminary injunctions in equal access cases to prevent Medicaid payment rate cuts where states have failed to make findings as to the impact that such cuts would have on access. *See, e.g., Ark. Med. Soc'y v. Reynolds,* 834 F. Supp. 1097, 1103 (E.D.Ark. 1992); *Long Term Care Pharm. Alliance v. Ferguson,* 260 F. Supp. 2d 282 (D.Mass. 2003), *rev'd on other grounds, Long Term Care Pharm. Alliance v. Ferguson,* 362 F.3d 50 (1st Cir. 2004). These preliminary injunctions curtailed potentially disastrous cuts in Medicaid provider rates. Had these courts not been empowered to act, there would have been no remedy at all.

CONCLUSION

All of the considerations discussed above weigh in favor of a right to sue, because (a) violation of the equal access requirement has been epidemic since the statute was passed 20 years ago, (b) the federal government has shown not the slightest interest in enforcing the law, and (c) even if, hypothetically, the federal government were interested in enforcing the law, its means of doing so would probably be ineffective in meeting the overall Medicaid goal of providing

medical care for the poor and needy. If it is otherwise, the rule of law will be eroded, and "equal access" will remain an unfulfilled promise.

Respectfully submitted,

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